I am Dr. Kevin Larsen, Chief Medical Information Officer of Hennepin County Medical Center in Minneapolis, Minnesota. We are a public teaching hospital with a fully deployed, integrated electronic health record, Epic. I was asked to represent the vendor based approach of interoperability, in our case, Epic's "Care Everywhere;" a software module allowing point to point provider exchange of individual patients' records in real time. We send the continuity of care record over the web enhanced with granular diagnostic and lab data, encounter information and providers' clinical notes. Nine large Minnesota provider organizations, with medical records of 75% of Minnesotans, went live with Care Everywhere over a year ago. Many other Epic customers across the US also exchange records using this system. In the last 6 months, my hospital has seen nearly 1200 attempted exchanges a month- representing nearly 3% of our visits. These are largely from Minnesota, but encompass 15 health systems across the country, as far away as California. We have many examples of enhanced care and reduced cost due to these exchanges.

It is no accident that Minnesota is a state of early interoperability. We have been working, for many ears toward an interoperable electronic medical record by 2015. By articulating this goal and committing to it, our provider community has invested early in electronic medical records, favoring those vendors that support integration and interoperability. We have a number of public and private forums where we have established a shared set of data standards, governance and a security framework.

In addition to Epic's CareEverywhere , my hospital and others in the state are interoperable with radiology PACS systems, joint clinical decision support platforms, e-prescribing, immunization registries and many administrative transactions. I believe Minnesota and the Epic vendor community have achieved this through a vision of a patient centered health record, where consumers are in charge of their information. Here organizations work to deliver health information to where patients want and expect it- other partners in the healthcare team.

We are currently giving automatic access with appropriate roles and authentication credentials via Care Everywhere. A couple of key issues arose that we needed to address. First, is <u>our</u> liability to breach by a user at <u>another</u> organization. Second, is, our ability to stop the flow of data or sanction an organization that demonstrates breach.

Currently, with the patchwork of state and federal laws, we need to exercise considerable control over access to our EHR data. We are especially cautious because the liability case law not yet established. We are also concerned about the full disclosure provision of ARRA and our ability to disclose access to our data by members of other organizations.

To date, we have chosen an all or nothing approach to electronic exchange. As our exchange includes both granular data and non-granular provider notes, we cannot assure that the clinical notes do not contain sensitive information. Therefore, if a patient requests that some information is not shared, our medical records department reviews all the notes prior to sending. I do not see this changing until we have natural language processing capabilities. We also have concerns about providing information that

is knowingly incomplete, such as not sharing a patient's life threatening allergy to an HIV medication because she does not want her HIV information shared.

I share the vision of the PCAST workgroup for national framework that allows patients to control the movement of their health information so that providers can provide the best care because they have access to complete, integrated and up to date information. Thank you for inviting me today.

HCMC CareEverywhere statistics:

6000 attempted transactions between 7/30/10 and 12/30/10

1038 incoming requests from 6 Minnesota and North Dakota Organizations

4750 outgoing requests to 15 health systems- 6 in Minnesota and 9 across US, (Wisconsin, Ohio, California, and Indiana) of these 2480 resulted in a record exchange. Many are unsuccessful due to the high degree of match necessary to assure patient identity.